Medicaid HCBS Waiver Payment for Community Transition Services: State Examples

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MEDICAID HCBS WAIVER PAYMENT FOR COMMUNITY TRANSITION SERVICES: STATE EXAMPLES

At least 37 states have implemented, or plan to implement, nursing home transition programs to identify people who wish to return to the community and to facilitate their move. Several states provide similar assistance for residents of Intermediate Care Facilities for people with Mental Retardation (ICFs/MR). Many of these programs are temporary, however, including state-funded pilots and Nursing Facility Transition Grants in 27 states funded by the Centers for Medicare & Medicaid Services (CMS) as part of the Systems Change Grants. Identifying permanent funding sources is particularly important for many states because most Nursing Facility Transition grants are scheduled to end by September 2005.

Medicaid can now pay most institutional transition program costs on a permanent basis as a result of policy changes since 2000. After summarizing these policy changes, this report describes how states are currently using the most flexible Medicaid funding option, community transition services, to support transitions. It also discusses how community transition services may complement other initiatives in these states that support deinstitutionalization.

Medicaid Options to Support Community Transition

CMS announced increased flexibility to support institutional transition under Medicaid in three letters to State Medicaid Directors between 2000 and 2003.[1]

- A July 25, 2000 letter (also known as Olmstead Update Number 3) announced the ability to use Medicaid funds for case management and home modifications before a person moves from an institution
- A May 9, 2002 letter announced the ability to use Medicaid Home and Community Based Services (HCBS) waivers to pay for certain community transition services—one-time items and services such as security deposits, moving expenses, and furniture that people often need when establishing a house or apartment
- A July 14, 2003 letter explained options for using Medicaid funds for medical equipment for transitioning residents

The flexibility and limitations for funding each service within Medicaid are described below.

Case Management

The July 25, 2000 letter announced three options states have within Medicaid to pay for case management to help institutional residents identify and access supports in the community: Medicaid administrative expenditures, the Medicaid State Plan targeted case management

[1] These letters are available on the Internet at http://www.cms.hhs.gov/states/letters/.

service, and the Medicaid HCBS Waiver.[2] In this report we use "case management," the term CMS has used in official communication. Some states use other names for this support, such as support coordination, transition coordination, and transition navigation.

Administrative Expenditures: The administrative expenditure option is the most restrictive in terms of the type of assistance it will fund. These expenditures are limited to activities required for Medicaid's "proper and efficient administration" (Section 1903(a) of the Social Security Act). For case management, administrative expenses are limited to helping a person obtain Medicaid services. This option cannot pay for helping people access non-Medicaid services and supports that transitioning institution residents often need, such as housing.

Under the administrative expenditures option, states have two types of flexibility that are not available under other options. First, states can pay for case management for an institutionalized individual over more than a 180-day period. Under the targeted case management service and the HCBS waiver, CMS guidelines limit the service to a maximum of 180 days before a person's discharge from an institution. Second, states can restrict transition case management providers. A state may prefer to use administrative expenditures if it wants only certain organizations to coordinate Medicaid-funded transitions, such as Centers for Independent Living or Area Agencies on Aging.

To bill case management as administrative expenditures, the state must ensure these expenditures are consistent with the state's cost allocation plan for Medicaid, which is approved by the regional offices of the federal Department of Health and Human Services' Division of Cost Allocation. To add a new administrative expenditure, such as transition case management, a state may need to amend its cost allocation plan. A few states indicated that amending the cost allocation plan was a difficult and time-consuming task.

Targeted Case Management: The Medicaid State Plan service "targeted case management" assists individuals "in gaining access to needed medical, social, educational, and other services" (Section 1915(g) of the Social Security Act). Unlike case management billed as administrative expenditures, targeted case management can help individuals gain access to housing and other supports in addition to Medicaid services. As an optional Medicaid State Plan service, states must have a State Plan Amendment approved by CMS to provide this service.

Unlike most Medicaid State Plan services, states can restrict targeted case management according to condition, age group, institutional status, geographic area, or other characteristics. To fund transition case management under this option, the state's target population must include institutional residents. For example, a target population of people with developmental disabilities may include people in ICF/MR. States may target all institutional residents, or they may target a segment of the institutional population, such as people age 65 and older or people with physical disabilities.[3]

[2] In addition to these options, states have the flexibility to provide transition case management within Research and Demonstration Waivers (authorized by Section 1115 of the Social Security Act) or Freedom of Choice Waivers (authorized by Section 1915(b) of the Social Security Act).

[3] For examples of State Plan Amendments that authorize targeted case management to assist people leaving institutions, see Mollica, Robert L. and Gillespie, Jennifer. "Targeted Case Management Discussion" National Academy of State Health Policy: February 2004.

States that offer targeted case management must offer a choice of qualified providers. The state may limit targeted case management providers when the target population consists entirely of people with chronic mental illness or people with developmental disabilities, to ensure the providers are capable of ensuring that the individuals in the target group receive needed services. Even when the provider pool is limited, targeted individuals retain their right of free choice among providers the state selects. For all populations, states must set provider standards that are reasonable for the targeted population. For example, if nursing facility residents are the target population, states could require that providers have experience facilitating nursing home transitions.

Waiver Expenditures: Like targeted case management, the case management service under Medicaid HCBS waivers assists individuals in obtaining both Medicaid and non-Medicaid supports. Unlike targeted case management, states may not limit who can become a case manager for groups of people with chronic mental illness and people with developmental disabilities.

Another difference between the HCBS waiver service and other case management options is that Medicaid cannot pay for waiver services until after a person moves into the community and enrolls in the waiver. The date of service for the first bill is the date the person moves from an institution and begins receiving waiver services. Officially, one unit of the waiver service "case management" is completed on this date. If a person does not move to the community and join an HCBS waiver, the state cannot use the waiver to pay for transition case management. This may occur if the person ultimately decides not to transition, if the person passes away before leaving the institution, or if the person is not eligible for the HCBS waiver. The state may use administrative expenditures or the targeted case management service if the state meets the requirements to use one of these options.

For a state to use an HCBS waiver to fund transition case management, the approved HCBS waiver must include the case management service in the approved waiver document. If the waiver is to provide transition case management activities, the nature and extent of these activities should be specified in the definition of services in the waiver.

Home Modifications

The July 2000 letter that announced the case management options also announced a new Medicaid HCBS waiver policy to pay for home modifications for transitioning residents. The policy is similar to the policy for transition case management under an HCBS waiver:

- The waiver may pay for home modification expenses incurred up to 180 days before the person moves into the community.
- The date of service is moving day, when the service is considered complete.
- An HCBS waiver cannot pay for a home modification if the person does not move into the community and join the waiver. A state may bill home modification costs for people who do not transition as a Medicaid administrative expenditure, if these costs are consistent with the state's cost allocation plan for Medicaid.

- If home modifications are an approved waiver service, the state does not need to specify that it will cover modifications for transitioning institutional residents, unless the nature or extent of the transitional service differs from the service available to individuals who already live in the community.

Community Transition Services

A new option authorized in a May 2002 letter to State Medicaid Directors, Community Transition Services, is the most flexible Medicaid option available for expenses people incur when moving from an institution. These services can include most of the one-time transition expenses that many states currently pay for under the Nursing Facility Transition Grants or state-funded pilot projects, such as security deposits, utility set-up fees, essential furnishings for a home or an apartment, moving expenses, and pest eradication.

States must amend a waiver to add community transition services. Like all Medicaid HCBS waiver services, states have great flexibility in how they define community transition services. Medicaid cannot, however, pay for certain expenses that many Nursing Facility Transition Grants cover. Medicaid cannot pay for room and board expenses for people living in the community. As a result, Medicaid cannot pay for an initial supply of groceries or for a person's rent.[4]

Community transition services are only available to people moving from a Medicaid-funded institution to a home or apartment. People moving to community residential settings such as assisted living facilities and group homes are not eligible for community transition services because the residential provider is responsible for household items, utilities, and other expenses.

Medical Equipment

All states are required to cover medical equipment as part of the Medicaid State Plan home health benefit. States may determine which equipment they will fund under their State Plans, consistent with guidance in a September 1998 letter to State Medicaid Directors. Transitioning residents, however, may need equipment that is not covered under the State Plan. States may pay for additional equipment under a Medicaid HCBS waiver. A July 2003 letter to State Medicaid Directors described when waivers can pay for transitioning residents' medical equipment, and provided additional suggestions for making equipment available to people leaving institutions.

An HCBS waiver can pay for equipment purchased within 60 days of a scheduled transition if the item is an approved waiver service or part of an approved service. For billing purposes, the date of service is the date the person moves and enrolls in the waiver. As is true for transition case management and home modifications as waiver services, a waiver cannot pay for equipment if the person does not move to the community and join the waiver. A state may bill medical equipment costs for people who do not transition as a Medicaid administrative expenditure, if the costs are consistent with the states' cost allocation plan for Medicaid.

[4] Some landlords may waive the first month's rent for a transitioning person. See http://www.cms.hhs.gov/newfreedom/transitions.pdf for more information.

In addition to the instances when HCBS waivers can pay for transitioning residents' medical equipment, states can pay institutions for specific items as part of the facility's payment. States and transition case managers also can make arrangements with equipment providers to make items available to residents for a trial period. Including items in institutional reimbursement, as Pennsylvania does with its Exceptional Durable Medical Equipment payment, may give facilities an incentive to purchase items that benefit only a few residents, or that a resident would want to keep if he or she leaves the facility. Some facilities transfer the title for equipment to a transitioning resident when he or she moves.

Summary of State Options

The following table summarizes the Medicaid funding options for each service, the percentage of expenditures the federal government would pay under each option, and the action a state must take to use each funding option.

Service	Funding Option and Federal Participation Rate	Maximum Time Before Transition	Necessary Approval
Transition Case Management	1. Billed as an Administrative Expense (50%) 2. Targeted Case Management Service (Federal Medical Assistance Percentage (FMAP))[5] 3. HCBS Waiver (FMAP)*	1. No limit 2. 180 days 3. 180 days	1. Must be consistent with the state's cost allocation plan for public assistance programs 2. Case management for institutional residents must be authorized under a State Plan Amendment 3. Case management must be an approved waiver service
Home Modifications	HCBS Waiver (FMAP)*	180 days	Home modification must be an approved waiver service
Community Transition Services	HCBS Waiver (FMAP)*	No limit	States must amend their waivers to add community transition services
Medical Equipment	1. State Plan (FMAP) 2. Nursing Facility (FMAP) 3. HCBS Waiver (FMAP)*	1. Not before transition date 2. No limit 3. 60 days	1. Equipment must fit the definition used in the state's home health benefit and may not be purchased while a person is in an institution 2. A State Plan Amendment is required to change nursing facility reimbursement 3. The equipment item must be within the definition of an approved wavier service
* States can bill service costs as administrative expenditures (50 percent) if the services are provided to waiver applicants who do not eventually join the waiver, and if these expenditures are consistent with the state's cost allocation plan for public assistance programs.			

[5] The Federal Medical Assistance Percentage (FMAP) is the federal government's share of Medicaid service expenditures. FMAP varies among the states and was between 50 and 77 percent in Federal Fiscal Year 2004.

Medicaid HCBS Waivers with Community Transition Services

Medstat identified thirteen states that have amended their Medicaid HCBS waivers to offer community transition services since CMS made this service available in May 2002: Indiana, Louisiana, Maryland, Massachusetts, Minnesota, Nebraska, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Texas, and Wisconsin. A few other states had submitted waiver amendments to add these services at the time this report was written. The number of people using community transition services is small. As of September 2004, some states had not yet provided these services because they had added the service to their waiver only months earlier (e.g., Louisiana, Minnesota, New York, Pennsylvania, and Texas). Oregon has provided community transition services to the largest number of people: 180 former institution residents since 2002.

Community transition services are primarily available to people leaving nursing facilities, although Oregon offers these services to eligible people leaving hospitals and a few states offer them to people leaving Intermediate Care Facilities for people with Mental Retardation (ICFs/MR). Twelve of the thirteen states with community transition services offer them to one or both of the populations most likely to be in nursing facilities: older adults and people with physical disabilities. The other state, New York, and four other states (Indiana, Louisiana, Pennsylvania, and Texas) made community transition services available to other populations such as people with brain injuries, people with HIV, technology-dependent people, and people with developmental disabilities.

This section answers several questions about implementing Medicaid community transition services that states have asked the authors and the National Technical Exchange, which provides technical assistance to the recipients of Systems Change Grants. These questions include how states:

- Define community transition services,
- Ensure that transition services are furnished by Medicaid providers, and
- Estimate costs and set funding limits for transition services.

Defining Community Transition Services

The Appendix contains the language from several states' waivers that define community transition services. Most states copied language from the May 9, 2002 letter to State Medicaid Directors that authorized community transition services. As a result, these states explicitly name the same components of community transition services itemized in the letter:

- "Security deposits that are required to obtain a lease on an apartment or home;
- "Essential furnishings and moving expenses required to occupy and use a community domicile;
- "Set-up fees or deposits for utility and service access (e.g., telephone, electricity, heating);
- "Health and safety assurances, such as pest eradication, allergen control, or one-time cleaning prior to occupancy."

Some states leave room to cover other items (e.g., Minnesota, Oregon, and Texas). This flexibility may prove significant for residents in those states who need unique items in order to live in the community. Nursing home transition grants have covered unexpected items people needed in the past, such as a birth certificate, bus passes, a driver's license, and registration for an accessible van the consumer owned.

In addition to setting out what services *are* covered, most states specify items that are *not* covered under transition services. These typically include rent and recreational items (e.g., purchase of a television or cable television access), which the letter to State Medicaid Directors also explicitly excluded. A few states further limit transition assistance by setting a minimum length of time a person must be institutionalized. For example, Minnesota and Maryland require a nursing facility stay of at least 30 days before a person is eligible for transition services. Indiana requires a 90-day institutional stay.

While the states generally adopted similar language to define transition services and what is and is not covered, there are different approaches to defining providers and how they operate. Some states, like Minnesota, encourage non-traditional providers such as discount stores (e.g., Target and Wal-Mart) to enroll in Medicaid. Other states, like Pennsylvania, primarily offer transition services through traditional providers such as agencies that provide waiver case management. These states allow the provider to either supply the transition services directly or broker the services from community sources such as retail stores.

Funding Limits and Cost Estimates

While many state staff expected nursing home transition programs to be cost-effective, several states set funding limits in order to manage the up-front costs of transition services. These states generally adopted the same funding limits that they had set during the state-funded transition program or their federal Nursing Facility Transition grant. Funding limits for transition services range from $350 in Oregon up to $4,000 in Pennsylvania. Oregon was the only state with a funding limit under $1,000. The low limit reflects the state's limited demand for comprehensive transition services, since the state significantly reduced its nursing facility utilization in the 1980s and 1990s. Minnesota and Wisconsin set no cost restrictions on community transition services, although these services and other waiver services must be within the waiver's overall expenditures limit. Average expenditures data for transition services were not available in most states because these programs have served people for only a few months.

Louisiana was the only state with different transition services funding limits for different waiver programs. The New Opportunities Waiver serving people with developmental disabilities has a $3,000 per participant limit. Two waivers serving older adults and people with physical disabilities have a $1,500 limit. The state first added transition services to the MR/DD waiver, and used historic transition experience to set a limit. When adding these services to the waivers for older adults and people with physical disabilities, Louisiana could not use the same limit while meeting the policy goal of transitioning 50 people a year. As a result, the state lowered the limit to $1,500. Since Louisiana has only provided transition services through the waivers for a short period of time, it is not clear whether the lower cost limit will affect nursing home residents' ability to transition to the aged and disabled waivers.

States also used their experience with Nursing Facility Transition grants and state-funded programs to estimate the number of people who would transition and the cost of transition services. This cost estimate (which is typically lower than the funding limit) is not only important for the state's program management, but is also required for waiver amendments that add new services to a waiver.

One state was an exception to this rule, and its experience may inform other states with no state-funded or grant transition programs. Minnesota's Elderly Waiver was the first waiver in the state to add transition services. The state did not have historic nursing home transition program data for people age 65 and older, because the only state-operated transition program targeted people under age 65. To estimate transition costs, the state used Medicaid claims data to calculate Medicaid expenditures for supplies and equipment for people who had previously moved from nursing facilities. The state then estimated the number of people who had moved from nursing facilities after short-term stays (30 – 90 days) to estimate the number of people who would use community transition services.

Other Initiatives to Reduce Institutionalization

The states discussed in this report have also taken other steps to reduce institutionalization. All of them offer transition case management to help people plan their transitions and access community services. Most states provide transition case management through the same organizations that provide case management for Medicaid HCBS waiver participants. Four states have additional deinstitutionalization initiatives that may complement community transition services.

Minnesota, for example, has trained counties (who provide most waiver case management in that state) and other case management entities about the potential for people to leave nursing facilities. Minnesota has also focused on downsizing and closing nursing facilities and large ICF/MR.

Maryland has also adopted diverse strategies to reduce institutionalization. The state's "Money Follows the Individuals Accountability Act" moves money from the state's nursing facility budget to the state's home and community-based services budget when a person moves from the facility and joins a Medicaid HCBS waiver. Maryland is also providing higher reimbursement rates for attendant care providers in comparison with other programs, and is exploring the use of managed-care organizations to coordinate and provide services. The Governor's Commission on Housing is examining housing barriers, which frequently delay nursing home transition, and the state has instituted an accessible housing registry.

Texas also has a law that moves money from the state's nursing facility budget to the state's home and community-based services budget when a person moves from a facility and joins a Medicaid HCBS waiver. In Texas, this law has helped 5,500 people leave nursing facilities and join a waiver in the last three years. Texas has also contracted with several organizations to provide transition case management through a state-funded pilot program.

Wisconsin also has a Money Follows the Individual initiative to facilitate transitions from nursing facilities into the community. The state set aside a certain number of slots in its waiver for older people and people with physical disabilities specifically for people leaving nursing facilities. Wisconsin also eliminated its individual limit on waiver expenditures, which was too low to serve some former nursing facility residents in the community.

Discussion

As the first System Change grants come to a close, more states are expected to examine using Medicaid funding to continue and expand transition initiatives. Since 2000, CMS has made Medicaid policy changes that increase states' flexibility to use Medicaid funds to help institutional residents transition to community-based settings. Medicaid can now pay for the following service and support costs under the circumstances described above:

- Transition case management;
- Home modifications;
- Community transition services, certain up-front costs needed to establish a community household; and
- Medical equipment.

Ten states already use Medicaid HCBS waivers to pay for community transition services, the most flexible option available under Medicaid for expenses people incur when moving from an institution. This report presents how these states have defined transition services, set provider standards and funding limits, and estimated the cost of these services.

This report also briefly describes how community transition services fit in the context of a state's long-term support system. While adding community transition services is an important step to permanently funding transition assistance, this service is a small component of the systemic efforts necessary to increase community options for Medicaid participants. Even with transition services, people leaving institutions often face many of the same challenges that many community-dwelling older people and people with disabilities face, such as direct support worker shortages, transportation challenges, and—in most communities—an inadequate supply of accessible, affordable housing.

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Appendix
Definition of Transition Services from
Approved Medicaid HCBS Waiver Amendments

Louisiana
New Opportunities Waiver (for people with developmental disabilities)

Transition start up expenses – are one-time, set-up expenses for individuals who make the transition from an ICF/MR to their own home or apartment in the community. This one-time lifetime maximum services of $3000 per individual, is for security deposits that are required to obtain a lease on an apartment or home and setup fees or deposits for utilities (telephone, electricity, heating by gas) and essential furnishings to establish basic living arrangements which are bed, chair, a dining table and chairs, eating utensils, and food preparation items and a telephone.

Minnesota
Elderly Waiver (planned to be added to the state's other waivers)

Transitional Services: Community transitional support services include expenses related to establishing community-based housing for persons transitioning to an independent or semi-independent community residence from a certified nursing facility or other licensed setting.

The expenses must be reasonable and may not include recreational or diversional items or expenses related to on-going rent or housing costs, food, or clothing expenses. This service does not include services or items that are covered under other waiver services such as chore, homemaker, home modifications and adaptations, or supplies and equipment.

Examples of expenses that may be covered are: lease or rental deposits, essential furniture, utility set up fees and deposits, personal supports to assist in locating and transitioning to the community based housing, basic household items, personal items and one time pest and allergen treatment of the setting.

To be eligible an individual must: (1) not have another source to fund or attain the items or support; and, (2) be moving from a living arrangement were these items were provided; and, (3) be moving to a residence where these items are not normally furnished (e.g., items cannot be provided in a setting where the setting is otherwise responsible to provide them); (4) if the individual is not presently using the waiver, the local agency must evaluate and reasonably expect that the person will be eligible for and will open to the waiver within 180 days; and, (5) incur the expense within 90 days of the waiver opening date.

Community transitional support services will be identified on the individual's plan of care and will be considered provided and may be billed after the waiver is open. In these situations, the local agency is responsible to make the determination that the individual meets all of the applicable eligibility criteria and is expected to move to the community within 180 days. If for an unforeseen reason the person does not open to the waiver (e.g., due to death, significant

change in condition, etc.), the local agency may bill for the service and be reimbursed through Medicaid administrative funds.

Oregon
Senior and Disabled Waiver

Community Transition Services are one time services including the following components: security deposits that are required to obtain a lease on an apt or a home; essential furnishings to establish basic living arrangement such as a bed, table, chairs, window blinds, eating utensils, and food preparation items; and moving expenses required to occupy and use a community domicile; set-up fees or deposits for utility or service access (e.g. telephones, electricity, heating); health and safety assurances, such as pest eradication, allergen control or one time cleaning prior to occupancy.

Texas
The following example is for the Community Based Alternatives. Identical language, except for the waiver name, is used for the Community Living Assistance and Support Services, Medically Dependent Children, Deaf Blind with Multiple Disabilities, and Consolidated Waivers.

Transition Assistance Services (TAS) are services provided to a Medicaid eligible Texas Nursing facility resident to assist in transitioning from the nursing facility into the Community Based Alternatives program. TAS are one-time initial expenses required for setting up a household. The expenses must be included in the individual service plan approved by the case manager and DADS and the costs cannot exceed $2500.

Examples of TAS include some or all of the following components:

- security deposits that are required to obtain a lease on an apt or home;
- essential furnishings and moving expenses required to occupy and use a community domicile;
- set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating);
- health and safety assurances, such as pest eradication, allergen control, or one-time cleaning prior to occupancy.

Essential furnishings in the above context would refer to necessary items for an individual to establish his basic living arrangement, such as a bed, table, chairs, window blinds, eating utensils, and food preparation items. Community Based Alternatives does not consider essential furnishings to include diversional or recreational items such as televisions, cable television access, or videocassette recorders.

Wisconsin
Community Options Program Waiver (COP-W) and Community Integration Program II (CIP-II)

Relocation Related Housing Start Up: Includes initial chore services and the moving of personal belongings as needed in the preparation of the selected housing arrangement. For rental property, the participant must have a signed lease. Costs such as security deposits, essential furniture and

the installation of a phone are included as needed for the intended community living arrangement of an individual relocating from an institution. Excludes rent and leisure/recreational devices. Excludes payments to parents of minors and spouses. All chore service providers must meet Supportive Home Care standards. (HSRS Standard Program Category 106.03)

Relocation Related Utilities: Costs associated with the connection of utilities as needed for individuals relocating from an institution – does not include cable TV. (HSRS Standard Program Category 106.01)

Because it is difficult to establish a process and time frame that fits every applicant, the allowable transitional services may occur up to 90 days prior to a discharge but must be completed and billed to the waiver on the first day the individual relocates from an institution.